T R A N S C R I P T

LEGISLATIVE ASSEMBLY LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into capturing data on family violence perpetrators in Victoria

Geelong—Wednesday 7 August 2024

MEMBERS

Ella George – Chair
Annabelle Cleeland – Deputy Chair
Chris Couzens
Chris Crewther
Cindy McLeish
Meng Heang Tak
Jackson Taylor

WITNESSES

Elaine Williams, Principal Strategic Adviser, and

Max Broadley, Independent Chair, Barwon Area Integrated Family Violence Committee; and

Karen Todd, Manager, Social Work, Barwon Health.

The CHAIR: Good afternoon. My name is Ella George, and I am Chair of the Legislative Assembly's Legal and Social Issues Committee. We will now resume our public hearings of the Committee's Inquiry into capturing data on family violence perpetrators in Victoria.

I begin by acknowledging the traditional owners of the lands on which we are meeting, the Wathaurong people. I pay my respects to their elders past, present and future and extend that respect to First Nations people across Victoria.

I am joined today by my colleagues Meng Heang Tak, the Member for Clarinda; Chris Crewther, the Member for Mornington; and Cindy McLeish, the Member for Eildon.

All evidence given today is being recorded by Hansard. While evidence taken by the Committee is protected by parliamentary privilege, comments repeated outside this hearing may not be protected by this privilege. Witnesses will be provided with a proof version of today's transcript to check, together with any questions taken on notice. Verified transcripts, responses to questions taken on notice and other documents provided during the hearing will be published on the Committee's website.

I am pleased to welcome Karen Todd, Barwon Health representative from the Barwon Area Integrated Family Violence Committee; Elaine Williams, Principal Strategic Adviser from the Barwon Area Integrated Family Violence Committee; and Max Broadley, the Independent Chair of the Barwon Area Integrated Family Violence Committee. I invite you now to make a brief opening statement of 5 to 10 minutes, and this will be followed by questions from members. Thank you.

Elaine WILLIAMS: Thank you, Chair, and thank you to the Committee for inviting us to present at this public hearing today. I would like to begin by acknowledging the strength and resilience of all victim-survivors of family violence. We keep at the forefront of our minds all those who are experiencing family violence today, and it is on behalf of them that we do this important work. I would also just like to mention that it is really important whenever we are undertaking these sort of policy pieces that we seek out and hear from the lived experience of victim-survivors.

I am aware that, I think, you have spoken with a few other Principal Strategic Advisers, but I will just briefly cover the Barwon Area Integrated Family Violence Committee, or we might use the acronym BAIFVC for short just for simplicity, which provides leadership, advocacy and specialist expertise to strengthen, integrate and improve the family violence service system and help end family violence across the Barwon area. Our membership includes representatives from specialist family violence services as well as broader cross-sector organisations and alliances whose work intersects with family violence response, early intervention and prevention. You have probably heard that BAIFVC is one of 14 Family Violence Regional Integration Committees, or FVRICs, as we call ourselves, across Victoria.

Just a comment, I guess, to begin with about data. In its most fundamental sense, data represents raw, unprocessed facts. But when collated, analysed, contextualised and interpreted, data becomes meaningful. When we talk about perpetrator data, we are therefore talking about people. We need to keep front of mind that behind each perpetrator statistic are women and children whose lives have been profoundly impacted by the perpetrator's choice to use violence. There are different purposes for which data on perpetrators is collected. The main one is for the purposes of assessing and managing family violence risk at the sort of client intervention level. We would also like to see an increased focus on the collection of data for the purpose of gathering evidence to understand why people perpetrate violence. Data also needs to be routinely collated to enable the effectiveness of interventions to be measured, particularly the long-term tracking of perpetrators to measure the impact of interventions over time. Data can be used to identify an unmet need or service or program gaps, which then enables specific place-based responses to be designed and delivered. Data is also critical to assessing how well local service systems are integrated. For example, is information sharing occurring? Are there blockages or barriers? Finally, data is critical to determining if we are achieving the intent of the Victorian Government's family violence reforms. Are we achieving the outcomes we set for ourselves? Are we holding perpetrators to account? Are we keeping perpetrators in view? Are we working collaboratively? Outcome data will enable us to answer these questions.

Just a final couple of comments about our reliance on technology for data collection and storage. As we are increasingly witnessing, when technology goes awry, it can have a significant impact. When IT incidents occur,

the importance and value of strong local relationships, such as those forged through FVRICs—the integrated family violence committees—come into sharp focus. And relationships and technology go hand in hand. There is a sort of symbiotic or interdependent relationship between data systems and people. I might just hand over to Max to make a couple of other introductory comments.

Max BROADLEY: Sure. What we know when we look at data in the justice system or the child protection system, family services and family violence system is that people have complex lives. There is a core group of Victorians that have particularly complex lives. What I think is important to think about with data is to think about it along a life course. We actually have visibility of people who end up being perpetrators of family violence early on in the system. We can see that they are often victims of family violence in the child protective system. They become perpetrators of family violence when they are adults and start having contact with the justice system as adults. And then they very often end up in the drug and alcohol and mental health services as adults, and we consider them true perpetrators. That life course picture is available to us looking at publicly available datasets currently. It is really important to be able to look at that data, because family violence responses need to be varied depending on age and stage and depending on presenting co-morbid problems that a perpetrator might have. We need to be able to diversify our service system to be able to get behaviour change at different ages and stages as early as possible and contextualised to people's unique circumstances.

Victoria has a really well appointed service system that could respond better. What we do not have at a regional level is that contextualised data. We can often find that data through agencies like Crime Statistics. We can often find that data through the Australian Institute of Health and Welfare. We can get broad macro-trended data, which is very, very helpful.

We have a great deal of trouble being able to find that data for a regional context, because the service system needs to adapt regionally. If we were talking to you from a postcode in outer Melbourne, we would have a different profile of population that had different life course experiences, which may require different responses to the drivers of that perpetrator's family violence. In regional settings that is different. The service systems across Victoria need data at a regional level to be able to adapt their service sector appropriately, because populations are different and the drivers of family violence in the populations are different. We need to be able to contextualise it. Does that make sense? Life course regionally contextualised.

The CHAIR: Thank you. All right. Karen, did you want to add anything at this point?

Karen TODD: I am here as the rep for Barwon Health. I am the Manager of Social Work at Barwon Health. One of the things I thought I could contribute was to tell you a bit about how we manage some of our data systems. I know you got a submission from Strengthening Hospital Responses to Family Violence—it was submission 47—and we were part of giving feedback. What is in there is very reflective of Barwon Health.

One of the differences for us I suppose to some of our other regions is we understand we are one of the highest health services as far as receiving requests for family violence information sharings, the FVISS scheme under the MARAM. We get on average about 60 to 70 requests every month at Barwon Health for information, and about 80% of those are for information about people who use violence, perpetrators of violence. We have had to put a process in place, which we are still developing and evolving, for how we provide that information to our external information-sharing entities and risk assessment entities, such as the Orange Door, child protection et cetera. We keep data on all those requests, so we know where they all come from. We know how long it takes for us to respond. We know whether they are around victim-survivors or perpetrators, and as I said, about 80% of those 60 are around people who use violence.

To put that process in place, we have our freedom-of-information staff look into our medical system and try to identify that person if they last presented at Barwon Health. We are a very big organisation, as you know – 9,500 staff across 20-something sites. We look into our system—where were they? Then that freedom-of-information person sends an email to a director of that clinical area. For example, if the last presentation was in our emergency department, it goes through to that person, and then they look at their team and say, 'Who is the right person to respond to this request?' That health worker—and it is usually one of the social workers, because looking at our staff we need to identify staff who are able to understand family violence risk-relevant information—when reading a file, trying to work it out when they are wanting to understand about that perpetrator's behaviour: 'What would be the information or the data that we could share to help better inform our response at the Orange Door?' or wherever they are trying to support that victim.

Going through medical records—and you are probably aware through this submission that some health services have electronic medical records, but we at Barwon Health are still not quite there. We still have paper files in many areas, which are scanned and put into a digital medical record. Our mental health service has an electronic medical record system. Our emergency department has a different medical system. So in doing this work it means trawling through multiple different databases trying to find things and teaching health workers around what we are looking for to help inform that response to people who use violence. We then have to complete the request and email that back to our FOI; and they email it back out to the requesting organisation. So I am just illustrating to you the work behind being able to share this data and this information.

We have, as all health services do, a lot of staff turnover. We have probably 500 to 800 new staff joining the organisation every year and are training our staff, keeping them skilled in knowing how to do this work, making sure people do it safely—that they share the right information and the data is kept appropriately. So we have that information, but at this point in time it is really the information sharing rather than the data we are not sharing with anyone, the amount of requests, who we share that with. That could be useful in some context. But our understanding, when we had to operationalise the Ministerial Guidelines for implementing the family violence information-sharing scheme, was that we needed to keep data on the requests coming in and the requests coming out. We understand we can also proactively share information. We do not do that as much. It really is a big cultural change in health to see family violence as a health issue—we are not family violence specialists—and understand that we do have an imperative to share this information with other services to keep people safe.

In social work we get about 600 to 700 referrals a year for family violence. Many of that is working with people who use violence—and I know in the SHRFV submission there was a comment that there are not standardised datasets across health. There are not minimum datasets across health to keep data on people who use violence or keep data on victim-survivors. Health services have had to come up with workarounds to keep this data, so for many years we had an Excel spreadsheet. We now, after working internally at Barwon Health, have created some codes where we can put this data into a system, but ideally I think these codes need to be developed Victoria-wide for all health services rather than health services developing codes individually, because if everyone was able to collect that data together using the same codes, we would have regional- and metro-based data seeing where perpetrators are presenting to health and, like Max highlighted, opportunities then for intervening early if we could identify people. So if someone at Barwon Health said to me, 'Can you tell me how many people might be presenting to Barwon Health who are perpetrating family violence?' I could not pull that data very easily.

So there is a really great opportunity if we could, as a Vic-wide health system, have some data codes created that staff then could use when they are writing in a medical file. We have coders that go through files, and then that is how things get coded under episodes and how our hospitals get funded. We could have coding entered then for the work being done—because we are working with someone who has used violence or we are working with a victim-survivor—and that data could be identified, and we would have much better ways of developing system responses, resourcing the work that needs to be done in this space.

The CHAIR: I have got two questions that are both follow-up questions from your opening presentation. Firstly to you, Karen, on hospital codes and coding what goes into your system: how would you practically go about getting a code that indicated family violence was present?

Karen TODD: There are not any, so we have had to create our own. There is what is called the Victorian Emergency Minimum Dataset. If someone presents to an emergency department and they have been injured, there are some codes for injury where it has been inflicted by another person, but the codes are not specific to family violence. So these codes do not exist. We have created our own internally, but there is nothing.

The CHAIR: And is this something that the Department of Health would lead?

Karen TODD: Yes.

The CHAIR: And do you know if other hospitals have also created their own codes?

Karen TODD: There have been lots of workarounds. I think Peninsula Health—the member over here is from Mornington—if they get someone presenting to their service who is a victim-survivor or a perpetrator, use their RiskMan, which is not really designed for this purpose. But they enter that. That is where there has been

an injury; they enter it into RiskMan as a way of being able to keep a record of these presentations. So there is a great opportunity there.

The CHAIR: Thank you. Did you want to follow up on that at all? No? Okay. The second follow-up question, Max—you were speaking about a lack of regional data: I am just wondering if you can elaborate on that, and is it that the data is not being collected; is it that it is not being reported by region or broken down by region?

Max BROADLEY: It is not publicly available. We are talking to you as an integrated committee, so we are an entity that sits amongst member organisations that are providers of family violence services, and this kind of goes to the next question, really, about barriers. All of those service providers will be collecting their own data, as Karen has talked about there. As you know, family violence is a highly prevalent issue. Perpetrators of family violence are moving into the system in all sorts of ways, not simply through the Orange Door reporting or not simply through L17. Perpetrator data is throughout the Victorian service system, and that data is not able to be aggregated into a regional picture (a) because it is not public data—it is organisational-owned data—and (b) because there are problems with authority in sharing data. So organisations do very well, and it is the core business of every community service and health organisation to constantly redesign their services to better respond to their presenting patients and clients. That is what organisations do all the time.

But what we know at a regional level, at a sector-based level, is that the drivers of violence might be complex. It might not be the core business of where that perpetrator is. There are really good examples of adaption of programming where someone is coming in for, let us say, a perpetrator service. Meli do this work, actually, where they had a men's behaviour change program and they noticed in their trended data that perpetrators with ABIs required an adaption of their basic men's behaviour change program, and they adapted that program. At a sector level a committee like BAIFVC that was equipped with good profile data, like volume and profile of the drivers of family violence, could join together different agencies to put in a collaborative response that would be a more fit-for-purpose response to that presentation. Does that make sense? So people who are perpetrating violence often have trauma, often have drug and alcohol presentations, they often have mental health presentations. Those presentations are different along their life course as young people to adolescents to adults. So if the question is: how do we get an accurate picture so that we can reduce the perpetration of violence? It has to be that the service system diversifies its model, because the model currently is not as well equipped as it could be to reduce family violence. Does that make sense? Am I answering that question?

The CHAIR: Yes.

Max BROADLEY: So the data is held in agencies, not publicly available, so we cannot do sector-wide design.

Karen TODD: One of the opportunities, potentially under the FVISS, the family violence information sharing scheme, is if organisations were more able to proactively share information about perpetrators to someone, whether it is the Orange Door or –

Max BROADLEY: Or an agency like ours.

Karen TODD: an internal agency that brings in, so schools, health et cetera. Could we identify behaviour and then we share that, because we are seeing it and observing it? That organisation then has the ability to do something about it.

Max BROADLEY: The way it currently works, at a model like BAIFVC, is we are a membership-based entity. We have members who are providers who see family violence. We create a forum-type model for partnership and networking, and in that forum model we share information that is anecdotal in nature, and that is voluntarily shared. For example, last year our member from VicPol shared his concern about the increasing rates of adolescents who are using violence—adolescent perpetrators. From that conversation we did some analysis on the data that was publicly available. It was not necessarily regional; some of it was, but some of it was state or national. We identified this growing trend of adolescents who were using violence in the home who will likely go on to becoming perpetrators who are in the mental health and drug and alcohol system. And through that analysis we were able to then present that back to the service centre locally and ask for an adaption of the available programming. The state funds an adolescent family violence program, which was historically a program funded to provide a service where teenagers are perpetrating violence against parents. What the data

showed when we analysed it was that there is a growth in adolescent-to-adolescent violence and that there was not actually a service system response for that; that was not what the state has funded. But as I said earlier, our organisation's core business is to adapt programming to presenting need, so presenting the data back to the service system gave them the opportunity to adapt their programming to prevent that form of violence. That came to us anecdotally through a networking forum.

There are all sorts of drivers and presentations of family violence that we are not seeing or that are not being presented to us anecdotally because we do not have access to the data to be able to analyse it. So our job in the middle of the sector, as a sector support mechanism, ought to be about looking at everybody's data, analysing it and presenting trends back to the sector to say, 'Do you realise this is going on in this region, in the Barwon region? Together we can do something about that.' But we rely on the voluntary sharing of anecdotal data to be able to make those decisions.

The CHAIR: Okay.

Max BROADLEY: Does that make sense?

The CHAIR: Yes, it does. Thank you. Cindy.

Cindy McLEISH: Thank you. It is interesting actually that you have mentioned young people and the increases in some of the adolescent stuff. As I am understanding it, it is not just men, it is also women. Can you confirm that?

Max BROADLEY: As perpetrators of family violence?

Cindy McLEISH: As young adolescents.

Max BROADLEY: Yes, we can. I can give you the statistics if you like.

Cindy McLEISH: Even better.

Max BROADLEY: 65% of adolescents who used violence in regional areas were young men and 35% were young women.

Cindy McLEISH: Is that surprising? Or was that surprising when you first –

Max BROADLEY: Incidents involving female adolescents using violence grew 20%, compared to 8% in 2015. So over the last nine years the incidence of female adolescents who use violence has doubled, more than doubled, so that is surprising. Yes.

Cindy McLEISH: Now, I am just thinking about what is publicly available, the information, and what is organisationally based. And you are saying that they could provide it voluntarily.

Max BROADLEY: Yes.

Cindy McLEISH: Have you asked for it?

Max BROADLEY: Yes. The sector asks for it all the time, because it is everyone's core job as an organisation to do this work, to adapt. The greatest volume of available data is through the Orange Door. And –

Cindy McLEISH: The greatest volume of available data?

Karen TODD: Yes.

Elaine WILLIAMS: Well –

Max BROADLEY: Is that true? Well, apart from crime statistics.

Elaine WILLIAMS: Well, it is probably the Crime Statistics Agency family violence portal. I guess now that the Orange Door have been around for a number of years, they have quite a lot of really rich data, but we

cannot access that as a non-member organisation of Orange Door. Yes, that is on our wish list, certainly, to be able to access –

Cindy McLEISH: The wish list for them for you to access or for them to provide information to you?

Max BROADLEY: For them to be authorised to provide information.

Elaine WILLIAMS: Yes, because they are currently not really authorised to provide that.

Cindy McLEISH: And what would be the problem from their point to do that? Anything?

Elaine WILLIAMS: I guess it is a decision for Family Safety Victoria as to the release –

Cindy McLEISH: We are hearing from them. We can ask them.

Elaine WILLIAMS: Yes, I would encourage you to ask them.

Karen TODD: To give you an example, with the work we were doing we were trying to understand whether our changes in health were making an impact. I contacted the Orange Door and said, 'Could you tell me how many referrals you're getting? Has it increased from health?' 'We don't keep that data, or we're not able to share it.'

Cindy McLEISH: Do you know which one it is? Is it that they do not keep it, or is it that they do keep it and they do not want to share it?

Karen TODD: Well, I think the calls they get in, I do not know if they actually code it by services. But they basically said –

Cindy McLEISH: The referral source, though, you would think –

Karen TODD: I imagine referrals would, but if it is coming from a health worker—and they said sometimes it might be a health worker and then the person rings themselves, so that was an issue. But then also my understanding is they are not able to share that information. It is not for public sharing.

Elaine WILLIAMS: Yes, they do not code, so a warm referral is not picked up. The organisation behind the warm referral is not picked up. It comes across as just the person presenting.

Cindy McLEISH: I just have another question actually about Barwon Health. When you say you are getting requests for information, that is on the perpetrator, is it?

Karen TODD: Yes. About 80% of them are on the –

Cindy McLEISH: I am just trying to work out the relationship. Is the perpetrator the one that is in hospital seeking services, or is it –

Karen TODD: Not necessarily, no. Most of the requests are from the Orange Door, so they might be –

Cindy McLEISH: So they are getting information not from the perpetrator but from the person who has suffered family violence?

Karen TODD: Both. They might be caring. They might get the L17 from the police. They are working with the victim-survivor, the kids and the perpetrator, so they contact us for information sometimes about both or either/or. They want to know: does the perpetrator have a mental health, drug and alcohol history? Have they been in your ED lately? Just to get an understanding of I suppose the person's engagement in health, what their mental health is like, and that helps inform the risk in the situation of working with the victim-survivors –

Cindy McLEISH: And also the person who has suffered from the violence: can you confirm that they have bruises or a broken wrist or something?

Karen TODD: That is right. How many presentations have they been in in our mental health service? They might be a young mum having a baby, so that is an opportunity for us. We are working with them through

pregnancy care, but Orange Door is trying to work with them to keep them safe. But the bulk of our requests are around people who use violence, and the bulk of them are people who are engaged in our mental health and drug and alcohol services. When we actually look at where that perpetrator is presenting at Barwon Health, it is mental health and drug and alcohol, which –

Max BROADLEY: And most visible there.

Cindy McLEISH: Sorry?

Max BROADLEY: They are most visible in that part of the –

Cindy McLEISH: That is exactly what I wanted to unpack, thank you.

The CHAIR: Thank you. Heang.

Meng Heang TAK: Thank you, Chair. Just a follow-up question on your wish list in terms of the available information in the existing database: how can service providers in communities like Barwon be supported to link the databases that are already available? We have already heard that the Orange Door –

Karen TODD: The Orange Door's database.

Meng Heang TAK: has it but not vice versa.

Elaine WILLIAMS: Yes, definitely the Orange Door. I think VicPol also have a significant amount of data from their LEAP database that does not necessarily become available through the Crime Statistics Agency. I think they can enter into LEAP the name of a person and be able to see that history. That is not possible for any other place other than VicPol, so greater access to VicPol data would also be great.

Max BROADLEY: I think our members would say that sort of individualised sharing of information and linking of datasets would be great for family violence risk assessment and management at an individual and a case level. It is a good but clunky scheme of requesting information between the Orange Door and Barwon Health, and that is good because it has released a lot of information that is risk-relevant to keep women and children safe. We are also really interested in trended data for sector design—non-individualised, completely private. It is frustrating that even that level of data is not authorised to be shared.

Elaine WILLIAMS: I think at the direct client level—I know this has come up in other submissions—expanding access to the Central Information Point beyond the Orange Doors to specialist family violence services would also be really beneficial. We have seen examples in Barwon—actually it was at Barwon Health—where the receipt of a central information report significantly changed the way that that case –

Karen TODD: Treatment and care for that person, yes. The system we have is very convoluted. It is the best we can put in place at the moment, but if all health services could have some sort of data system, IT system, that could keep these requests as they come in and as they go out so there is some transparency with key people that can have access to see this—at the moment it is reliant on individual people. It is reliant on emails. If someone goes on leave, is it sitting in their email box? We are trying to create a SharePoint site that a few people will have access to so we can actually see, because as I explained before, it has got to go through different people. It comes in, goes through, someone responds and then it goes out and we scan it and save it in a special tab. A purpose-designed system that could work for all agencies, schools et cetera, that was specifically set up so that key people could use would be amazing, wouldn't it? That would streamline all of this.

Meng Heang TAK: I think you already answered part of my question. The next question is: how can this be overcome? Streamlining is another way, you say?

Karen TODD: Yes.

Max BROADLEY: We have asked that question for many years in different sectors—in the child protective sector, in the justice system. We come up with the same problem. To be able to prevent child protective issues or youth justice issues—we know that people's lives are complex. There are multiple presentations across time into different parts of the service system. So if you could somehow have a single-client view or an aggregated

view of that client, then you might be able to provide a better service response to them. That problem has existed in all parts of our service sector for a very long time. There have been calls over time to have a radical reforming change to data collection and data sharing, but it has not been able to be realised in any sector as yet. It is a difficult and problematic thing to achieve.

Karen TODD: I think, Max, as you were highlighting before, family violence is very complex and it is not just an admin process, this information sharing. You need people at each end who know what they are looking for, so you need health workers who also understand family violence, who can read a medical record and understand what is the risk-relevant information in there in regard to family violence. You need the right people with the right training and skills at each end. If it was in a school, you would need those staff to understand what is the information that the Orange Door need to know.

Max BROADLEY: For example, 68% of perpetrators who have a deteriorating presentation with regard to their perpetrating violence have a corresponding increase in their mental health symptomology—their mental ill health. So that means that there is a predictable cohort of people in the mental health service system that we could identify are likely to have deteriorating family violence behaviours, but we actually do not have the maturity around the practice or the workforce infrastructure or the ability to look at that data at an individual or aggregated level.

Meng Heang TAK: Thank you. Elaine, you said that one of the reasons you could not access the information of Orange Door is because your organisation is not a member. So is it fee paying—or what does membership mean?

Elaine WILLIAMS: I probably should say 'partner agency' rather than 'member'. Those organisations that are delivering the specialist family violence and child vulnerability services within the Orange Door can access that data and can also make requests at a Central Information Point. Services or agencies that are not part of that service model cannot or they have to ask the Orange Door to do it on their behalf almost, so that is the difference.

In terms of, I guess, a wish list, I think you have probably already heard about misidentification of the primary aggressor. It would be really great to be able to fix that or to be able to rectify that misidentification in data systems, because it is really hard to do that at the moment. I guess one of the other things is that ability to be able to track perpetrators over time and also be able to know perpetrators who might have multiple victim-survivors—that is hard to see at the moment. Just another comment about using data obtained through MARAM risk assessments: noting that those assessments are at a point in time and those risk assessment levels change, there is always a bit of a caution, I suppose, about using that. You need to start somewhere, but risk is dynamic and it changes frequently.

I guess the other dilemma we have is about perpetrators of family violence that do not really interact with the community or social or justice service systems, who are really invisible in many ways because they just do not seek services or they do not come into contact where their details will end up on a database somewhere. I do not know the answer to that, because there may be more engagements with the private service sector. It is challenging, and I do not have the solution for you, but I guess the VicPol data is not the complete picture.

Meng Heang TAK: Thank you. Thank you, Chair.

The CHAIR: Thank you. Chris.

Chris CREWTHER: Thank you, Chair. Thank you for your evidence and your time once again today. Adding to the Chair's question earlier regarding not having contextualised data at the regional level, as you raised earlier, Mr Broadley, do you think if we did have access to contextualised regional data we would also need access to subsets of that data as well to cover places like Colac, which might differentiate from Geelong? And could you expand upon the differences and barriers between different subsets of the Barwon region as to between those different areas?

Max BROADLEY: Sure. It would be fantastic to have subregional data. The Barwon region has a major regional city, the city of Greater Geelong, but has many regions that are hours away from a big regional city, so it is diverse in nature. It has farming communities and an inner-city community, for example, so we do see differences in the rates and types of family violence that occur across the Barwon region. And of course there is

a different service system infrastructure across the region, therefore responsible for responding to their local presentations. So subregional information would be good.

We know, for example, I think the rates of per capita family violence in the Colac region are probably much higher than they are in the Geelong region, and there are fewer providers to respond to that. So empowering those providers with the right information would be great. And the profile and the drivers are different, so whereas Geelong might have a larger Aboriginal community, a new arrival community, the outer regions have a more predominant farming community, Anglo-Saxon et cetera. The age distribution around the region is also different.

And so those individual contexts are really important, because they require a different program response. If you want to ask someone to change their violent behaviour and they have a complex life with a number of co-morbidities, like mental health or drug and alcohol or past trauma or sort of gender values, they are all different service system responses to be able to effect change in that person's behaviour. So that kind of granular-level information and data is empowering to service providers, because they will adapt their programming, because their interest is in reducing violence, in changing this behaviour. But without that kind of granular-level data each provider needs to find that organisational bandwidth to look at their own data, find the organisational bandwidth to then make partnerships with allies that have a common interest in that presenting client, to do service redesign, to implement new programs, to evaluate that—and we are talking about agencies that are providing health and community services, so they are really busy because they are the front-end service providers. So an entity like BAIFVC, which sits amongst the service providers—we are a tiny, little thing—would be very well placed to be able to do that analysis on their behalf and assist them in service redesign, partnerships, evaluation.

Karen TODD: Colac Area Health is on BAIFVC.

Max BROADLEY: Colac Area Health, yes.

Karen TODD: So with doing the work we did with the strengthening hospital response we worked with Hesse health, Colac Area Health and Great Ocean Road Health, and then in the last year or so we have been working across right down to Warrnambool, Portland and Port Fairy with our project. Every health service is so different in the resources they have got; the infrastructure is different, such as databases. Some do not have social workers, so it is very generalist staff. Even getting them to see that family violence is their business and their work—there are lots of challenges.

Elaine WILLIAMS: We are able to pull some LGA data from the Crime Statistics Agency Family Violence Dataportal, so we can—it is a very kind of broad level, though. BAIFVC has created—I have got copies here—infographics that we update every year just at the very high level, like incidents of family violence rates per 100,000 population and the variation across the four LGAs. But we would love to be able to drill down a lot further into that data. We can get some LGA data from the CSA website, but it is primarily just VicPol L17 data aggregated.

Chris CREWTHER: Thank you. Do I have time for one more, Chair?

The CHAIR: Very quick question.

Chris CREWTHER: You mentioned earlier about anecdotal evidence regarding adolescent-to-adolescent family violence and potential growth in that area. Is it the case that the data is not identifying sufficiently that subset at the moment? How can we actually improve data around adolescent-to-adolescent family violence?

Max BROADLEY: It is a new trend, so that is how that came about, I would say—that is just a new event, a change in presentation. That data is generally drawn from L17 Crime Statistics Agency data. In order to understand the service system we also sometimes rely on research data, so ANROWS, for example, do a lot of research and do a lot of number crunching, and the Australian Institute of Health and Welfare. So we rely on those much larger agencies who have relationships and authority to be able to get data, de-identify it and then present it back in a research paper. So we sort of rely a little bit on that.

Elaine WILLIAMS: I think too that data is now probably sitting in the Orange Door, so those L17s are going into the Orange Door. So again, being able to have access to that data would be really good.

Chris CREWTHER: Yes.

Max BROADLEY: It is probably important for the Committee to note that the restriction on the Orange Door sharing data is well-meaning in that the sharing of risk-relevant information is highly sensitive because of the risk that perpetrators increase their rates or severity of violence, so it is closely held for a sincere reason, and it is also closely held because the Orange Doors are delivered directly by the state. So that is probably the background on why that restriction on sharing that data exists, but we think there is more ability to share safely.

Elaine WILLIAMS: To be fair too, the Orange Doors are a new service model and built from scratch, so including the CRMs and the TRAMs—and hopefully you have heard those acronyms—it took a while for some of those data issues to be ironed out, so there was a tentativeness, and probably correctly so, about the data in the Orange Doors, but now that they have been operational for a number of years I think some of those concerns have either been corrected or allayed. Hopefully the data is becoming much more reliable and much more rich in nature.

Chris CREWTHER: Thank you.

The CHAIR: Thank you. Thank you to Max, Elaine and Karen from the Barwon Area Integrated Family Violence Committee. We are incredibly grateful for the evidence that you have provided to the Committee today. Thank you very much for coming along.

We will now take a short break and be back later this afternoon.

Witnesses withdrew.